

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN105AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/02/2010
NAME OF PROVIDER OR SUPPLIER CARSON VALLEY RESIDENTIAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1189 KIMMERLING RD GARDNERVILLE, NV 89410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility from 10/5/10 to 12/2/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for 84 Residential Facility for Group beds for elderly and disabled persons, Category II residents.</p> <p>Complaint #NVN00026581: The allegation regarding the refundable pet deposit was substantiated through interviews with facility staff, the facility administrator and resident family members and a review of admission agreements, letters to the facility from the complainant and house rules. See Tag Y0645.</p> <p>The allegation regarding level of care charges was substantiated through interviews with facility staff, the facility administrator and resident family members and a review of admission agreements, new admission check lists, care level ratings, incident reports, assessments of daily living, letters to the facility from the complainant, and facility communication forms. See Tag Y0645.</p> <p>The allegation regarding room rental charges was unsubstantiated through interviews with facility staff, the facility administrator and resident family members and a review of a new resident</p>	Y 000			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 000	Continued From page 1 department routing slip, new resident department routing slips, letters to the facility from the complainant, and facility communication forms. The following deficiencies were identified:	Y 000			
Y 645 SS=D	449.2704(1)-(5) Rate Agreement NAC 449.2704 The administrator of a residential facility shall, upon request, make the following information available in writing: 1. The basic rate for the services provided by the facility; 2. The schedule for payment; 3. The Services included in the basic rate; 4. The charges for optional services which are not included in the basic rate; and 5. The residential facility's policy on refunds of amounts paid but not used. This Regulation is not met as evidenced by: Based on interview and record review from 10/5/10 through 12/2/10, the facility failed to provide accurate information regarding pet deposit refund policy. The facility failed to accurately document the care level rate determination in the rate agreement for 1 of 1 residents. Severity: 2 Scope: 1	Y 645			

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